

Michigan Statewide Trauma System Focused Review Documentation Report

| Complete this template and attach to documentation submitted. |
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| Hospital: |
| Date of Original Site Visit: |
| Designation Level: |
| Documentation Submission Date: |
| Corrective Actions Note identified deficiency(ies) from original site visit and document how the facility has taken corrective actions. (Please format each deficiency as follows): |
| Deficiency: |
| Corrective Action(s): |
| |